MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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10:36 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Mandated report on certified registered nurse first assistant study
-- David Glass, Jill Bernstein

MR. HACKBARTH: We are to the last item for today, I think. This is a final mandated report. Not a final one, but another mandated report on certified registered nurse first assistants and their eligibility for payment.

MR. GLASS: Yes, that is correct. Again as one of our mandates we're supposed to study the feasibility and advisability of paying certified registered nurse first assistants directly from Part B. It's due January 1.

The current situation is that only physicians and specified non-physician providers can bill Medicare separately for first assistant at surgery services. The list includes physician assistants, certified nurse midwives, clinical nurse specialists, and nurse practitioners, though physician assistants account for much of the bulk of the first assisting done by NPPs who are paid separately. Those not on the list cannot bill separating. That includes CRNFAs and also surgical technologists and others.

NPPs are paid 13.6 percent of the physician fee schedule amount, which is 85 percent of the 16 percent that physicians get if they perform first assistant services. They get that 16 percent for every service. There is no distinction between different kinds of procedures or anything. It is always 16 percent of the physician fee schedule, and therefore 85 percent of it is always 13.6 percent.

Background here. The Omnibus Budget Reconciliation Act of 1986 allowed the physician assistants to bill as first assistants and they were paid 65 percent of the physician first assistants fee at the time. The expenditures were to be subtracted from the hospital payments. This did not happen. In fact in OBRA '90 they rescinded that payment subtraction. It's an important point though. From the beginning, the payment for physician assistants and first assisting services were recognized as duplicating hospital payments. PA first assistants, along with OR nurses and other OR personnel were considered part of the services the hospitals were providing, and therefore were considered to be included in the hospital payment.

Now BBA of 1997 removed some of the geographic restrictions on nurse practitioners and clinical nurse specialists. Before they could only do some things in rural areas and get paid separately for it. Now this was extended to all areas. It also made uniform this 85 percent payment. So instead of being 65 percent for first assisting and 75 percent for some things and 85 percent for others, they just made it 85 percent across the board.

What does this all add up to? Since BBA '97, the payments for physicians providing first assistant services have gone from $166 million to $104 million in 2002, and for non-physician practitioners it went from $16 million to $54 million. So the

total actually has gone down over this period. I want to note here that most surgeries do not use separately billable first assistants at all. The assistant is simply supplied by the hospital, and that is still true. The people who could be doing that might be residents, and they are not allowed to bill separately because they are considered to be paid under GME. And it could be others such as CRNFAs.

We cannot really tell if this is substitution of NPPs for physicians or not, but it's certainly not out of control and it doesn't seem to be big dollars in Medicare terms, even though the NPP part is growing.

So who are those CRNFAs who would like to be separately billable? They are people who are licensed as registered nurses in all 50 states. They are certified in perioperative nursing, which is an OR nurse, which requires two years and 2,400 hours of practice in itself, and then another 2,000 hours as RN first assistant. There is a formal RNFA program, and there is a certification by the certification board of perioperative registered nurses.

Right now they have to have a bachelor's or master's in nursing, but that's a fairly new requirement and only about 38 percent currently have that qualification. Finally, this is a very small number. There are only about 1,700 in the US. As we showed in the issue paper, there would be a small effect on the payment if they were added to the list. We would like to point out though that more could seek certification if it became more valuable.

So the question is, should they be added to this list of separately payable? The problem with answering the question is that there really aren't any explicit criteria for Medicare separate payment. We could infer some things from the current list. We can look at the current list and say that they're all state licensed and have a certifying board, and they meet that requirement. There's no surgical experience required explicitly for the current list, and education varies. So it is hard to say -- there is no criteria to meet in those cases.

Once on the list, certification requirements could be changed by the group, which is an interesting thing. For instance, the CRNFAs just increased the education requirement in their case.

So you really cannot answer the question, should a group be added, by simply looking at the current criteria, either the explicit ones, which are none, or the ones that that we can infer, though we do have some experience to guide us. The Commission has taken some positions on this in the past. In looking at non-physician practitioners, we discovered that there really was not any empirical evidence for the amount of payment for first assisting by physicians, or by implication, by non-physician practitioners. All procedures were paid the same at 16 percent to physicians no matter what they do.

We also discovered there didn't seem to be any clear difference in outcome with physicians or NPPs, but there certainly was less educational input for the NPPs. And we have recommended that -- so the 85 percent seemed to have some

justification. We recommended 85 percent for all NPPs. The certified nurse midwives are still at 65 percent for first assisting.

Now the Commission also did not add to the list when it was asked, orthopedic physician assistants or surgical technologists. The issues were really licensure and duplicate payment. Orthopedic physician assistants were only licensed in three states and surgical technologists only in one. As we pointed out earlier, all the NPP first assistant payments were included in hospital payments, so that's the duplicate payment issue. That was an issue when the Commission looked at this in the past.

Now GAO really came up with some of these same issues when looking at this question of adding CRNFAs to the list and concluded that payment for first assistants is already in the hospital payment and should not have a separate at all. CMS' position when they were responding to the GAO study in a letter said it's important not to disrupt the existing relationships, and therefore they weren't planning on changing policy, although they recognized that current policy had some inconsistencies.

So where do we go from here? You have to bear with me a minute. It seems like a large reaction to a small question, but where logic would carries on this, and the preferred solution would be to combine the global surgical professional fee and the hospital payment. The reason is that we would like to recognize the complicated reality that is out there. Some surgeons routinely bring staff with them. Others don't. And different types of providers are used by different surgeons; technologists, CRNFAs, PAs. And different hospitals employ different people, and they have different capabilities, and some have residents. So there is no one way of doing this.

Under this idea, the surgeons and hospitals would determine who should assist and who would get paid. They would figure out who is the best person to be doing it and they would divide the payment to reflect who supplies the assistants. If the physician brings the assistants with them, then he would get a larger share than if the hospital supplied the people.

Another advantage of this, it would link payments to global outcomes. So in terms of our quality work we would be able to say, what's the quality of the entire outcome and we would not have to say, this much of it is the surgeon's responsibility, and this much is the hospital's, and this much is first assistant's responsibility for quality. I think that is something that came up a little while ago. So it would have some benefit there. And it may allow more rapid response to new circumstances and technologies.

It could be that some new technologists, maybe a surgical technician is the best person to do it because it requires a lot of intense training on a very specialized thing. This would allow the surgeon to go ahead and employ that person if he thought they were best. Medicare wouldn't have to choose, would not have to set lots of criteria, would not have to get involved in all these really clinical decision issues. But it is clearly a major departure and there are lots of issues with it. There's the anti-kickback question. If a hospital is splitting a payment

with a surgeon, that could be a problem. But we see it's already being done in some cases. The hospital is reimbursing, or they call it leasing, staff from surgeons who bring their own assistants with them. So we think that would be something you can overcome.

You would have to figure what to do with the existing first assistant payments. You could consider them all duplicates and just take them away, or you can add it to the bundle, or if you wanted, you could put it in a quality pool. You'd have to decide whether this was going to include the physician first assistant payments as well as the NPP payment. Then you'd have to design your quality program and figure out quality measures and all that sort of thing.

By why do such a major redesign in response to small question? We think that logic draws us there, because the current system is inconsistent and unsatisfactory. It could be also a useful test case for paying for quality and for coordinating care between silos, between Part A and Part B, which are both major Commission priorities. From the beneficiaries's perspective, they really don't care if the person taking care of them works for the hospital or the surgeon, or what kind of practitioner it is. They want to know they will be safe and well cared for and get well as soon as possible. So if changing the payment system makes that more likely, it might be worth trying.

But recognize it's kind of a big recommendation to rest on this small of a study, so in the interim we could consider the following draft recommendation which would recognize that right now there is no sound basis for extending the list of separately billable NPPs at this time. There's no clear criteria. We can infer that CRNFAs are not disqualified, but we can't say they should be added with certainty.

To cope with the constant demands for additions to the list, it might be useful for CMS, through a regulatory process, to develop explicit criteria for licensure, education and experience. They would have to say how much experience and training qualified each type, and perhaps have rulemaking, complete with comment period and all that sort of thing, which could bring more information to light or start a foot fight between types of providers, but it might be a good way to do it, though it would probably be more bureaucratic and somewhat unresponsive to technical changes, for example. We would want to do it in a budget neutral manner.

It would be different from how Medicare treats physicians. Typically it says in law who can bill by type, M.D. or a P.A. or whatever, and it lets the states tell Medicare who is qualified under state rules to do one of those things. It doesn't say that surgery can only be done by physicians with so many years of training and experience. It simply says if someone is an M.D., they've been licensed by the state, then okay, they can do whatever services M.D.s can do in that state.

It also would not address the duplicate payment issue.

So anyway, we recognize it's not an optimal solution, but that's where we have arrived at here. We would like some direction from the Commission on how to proceed with, and do you

like one of these approaches or some other approach to be sent to Congress.

DR. WOLTER: This is kind of a niche question, but I'm wondering if there are any more remote areas with a general surgeon where the supply of these personnel would be enhanced by the extension and where they don't have availability of residents or other first assistants. You might imagine that as a niche issue that this might affect some unique locations.

MR. GLASS: Yes, if you are concerned about access -- some of these people are already there, they're just not getting paid separately, and they're already assisting at surgery. One issue might come up if the new work rules for residents go into effect, there may be fewer residents available to assist. If other payers paid for CRNFAs, whereas Medicare did not directly, then there could be some question of access for Medicare beneficiaries. But that's speculative.

MR. MULLER: I share your sense that what you call the preferred conclusion, it may be too big a response to too small an issue, and it takes on much more than we need to. So I think I share Nick's sense as well, maybe here and there, in some settings where there's an access issue we might consider that, combining the surgical payment and the hospital payment in response to this. I think we need a bigger issue to go to that kind of conclusion.

DR. MILSTEIN: I hate to be repetitive in my comments, and I think my comments do reflect, I'll call it the perspective and perhaps relative desperation of my constituency, people purchasing health care. But I'd obviously like to, as you might expect, applaud the more innovative recommendation. I think it aligns beautifully with what the IOM is telling us about the need for payment reform, and then giving the delivery system flexibility as to how a given service is manufactured.

It also would dovetail beautifully with an extremely progressive initiative by the American College of Surgeons called their surgical complications improvement program, which essentially is building off a highly successful risk-adjusted outcomes monitoring program for surgery that was pilot tested by the VA and is now firmly ensconced, generated big improvements. So they've now teed that up and they have it ready to go outside of the VA. But the history of the uptake of these programs is that if there isn't any economic incentive to go through the agony of information collection and reporting, the uptake has historically been very disappointing and resulted in a number of cases in progressive specialty societies shutting down a system just do to lack of subscription.

So I think the time is right, and I certainly agree with comment that it's a big change, it's a big recommendation relative to the scope of what we were asked to answer. But I think we need to be opportunistic and the hour is late.

MR. HACKBARTH: Let me just pick up on that for a second. My concern about the more conceptually attractive approach of bundling everything together is not so much it's scale relative to the mandate, but rather it's scale relative to the resources available to do it. My take on this is that CMS has other fish

to fry that are of greater importance right now than reshuffling this particular deck. Reasonable people can disagree on that, but that is my particular take.

MR. SMITH: I end up where you do on that one. I prefer the preferred solution, but I think that is an awful weak mule to try to carry this large a recommendation.

But I do wonder, David, you're right, the law doesn't give us any particular guidance here, but wouldn't the inference be that these folks are more like people who can now bill separately than like those who can't now bill separately, and that we talked about when we talked about the surgical assistants and the orthopedic?

MR. GLASS: Everyone else can not now bill separately who isn't on the list.

MR. SMITH: I understand.

MR. GLASS: But in the sense that they are licensed in states --

MR. SMITH: That they're licensed in all states, they have some specialized training to serve as a surgical first assistant.

MR. GLASS: Yes.

MR. SMITH: Actually, I think a recommendation that said, yes, they ought to be able to bill separately is more consistent with the notion that we ought to allow the providers to organize the manufacture of the service in the way that they think fits best, and that there is no particular reason to exclude this group of nurses with advanced training beyond the licensure, from participating as a physician's assistant or an otherwise now eligible individual can. So I would be inclined, with exactly the same argument that you lay out, to come to a slightly different conclusion based on equity grounds.

DR. WAKEFIELD: I'd just say on the front end, I agree with David. I just wanted to comment on Arnie's point and yours, I think your comment about, clearly CMS has bigger fish to fry than moving toward picking up maybe the preferred solution. But I don't see CMS pursuing this draft recommendation anytime soon either, not that I'd have a clue about how their internal workings operate. But I would be shocked if they moved into trying to develop explicit criteria around licensure, education and experience of different types of non-physician providers. If they do it in this century I would be surprised, in part because of your argument. That is, they've got so many other things. So I don't see this as any more palatable than the other, first of all.

To me there seemed to be this underlying issue that you talked about about bad policy. That is, that we've got redundancies in payment built into the system already. That is part of what we could use this to talk about. Notwithstanding David's earlier remark too but there is that inherent, it seems duplication of payment, although you caveat it a little bit in the text, can be thought of as duplicative. It sounds like it is. So that is another issue.

I guess all I'm saying is, I personally am not compelled by the draft recommendation that we've got here. In the short term

I'd agree with David about another alternative, but still there are these other big issues out there.

MR. BERTKO: I can only say amen to Mary's last comment, that if we go forward with anything except status quo we've got to equally emphasize being budget neutral.

DR. REISCHAUER: I think I asked this same question the last time we were in a topic like this, which is, do we have any idea what private plans do, the extent to which they separately reimburse?

MR. GLASS: Yes, some do, some don't. In 10 states they have to reimburse.

DR. REISCHAUER: They're required to. Am I right in inferring from what you say that for virtually all procedures, a minority involve a physician assistant of any kind? I mean, an assistant in surgery of any kind?

MR. GLASS: No, that is not quite right. There are certain procedures that --

DR. REISCHAUER: Always have them?

MR. GLASS: Yes, the American College of Surgeons says should always have been. But they are not often separately billable. They're not always separately billable people. They could be a CRNFA who works for the hospital, and they wouldn't be separately billable, but they're still assisting at surgery. We don't have visibility of how often that happens.

DR. REISCHAUER: But we don't know how often that is. Because I'm sitting here trying to square the current procedure and what we are considering with our mantra, which is we want to pay the efficient provider. If 80 percent of the cases it's done without an assistant and 20 percent it isn't, then you have to say, which is efficient?

We don't know enough to know the answer. The assistant could be there to improve quality, could be there to make the surgeon's job easier so he can get on the golf course, could be there because the hospital wants to make the procedure faster so it can run more things through the operating room. In some sense we need to know the answer to that before we know what our policy should be with respect to paying in a way other than that budget neutral.

DR. NELSON: I don't have any problem with the preferred solution if the combined global surgical professional fee and hospital, if the check is written out to the surgeon. There are indeed a lot of surgeons, or some surgeons who enjoy working for the hospital. But there are a lot who don't. I think if we even hint at that being a preferred solution, we are stirring up trouble that we just don't need right now.

MR. DeBUSK: I agree with David and Mary and some of the others around the table. These people have the license, they have the education, and they certainly have the experience, and today we are in major need of these kinds of people in the medical setting. I don't see how we can turn them down if we're going to let these other people be paid.

DR. WOLTER: Just a clarification. The idea was that all surgical fees for all surgical procedures, whether or not there was a first assistant, there be a combined global fee created, or

was it for only those where there was a first assistant?

DR. MILLER: You could do it either way. I think the presumption when we talked about this would be to identify the procedures that most often use the first assistant, at least as a starting point.

MR. MULLER: The issues we'll discuss tomorrow morning on specialty hospitals now being every hospital in America, and the issues of whether there is conflicts of interest and concerns about excessive, inappropriate utilization would be exacerbated to every OR in America, so I think it's just you have to look at the elegance of global fees against the reality of how it affects economic incentives very powerfully. So I could just as easily argue that this creates enormous possibilities of changes in utilization in ways that we are not looking to increase.

MR. HACKBARTH: I think the point made by Mary and Dave and others about the practicality, if you will, of asking CMS to establish criteria is a good one, which leads you to the conclusion, since they do meet the licensure threshold, unlike some of the others that we have looked at recently, saying let them in, but make it budget neutral. I see some nods that that might be a way to go. Could I get just a tentative show of hands? This isn't our official vote on this, but I want to be able to give direction to the staff for the next meeting. Who would like to see us move in that direction?

[Show of hands.]

MR. HACKBARTH: I know we have a couple who still like the more complete, conceptually clean solution.

MR. DURENBERGER: I don't know that I've heard any solution around here other than the one that we were asked to address and which you've modified. I am more concerned about the report language than anything else, because the best part of the preferred solution is the global outcome, because that is the way beneficiaries are going to look at this. If we care about the beneficiaries as much as we do the 1,700 CRNFAs than the most important thing is the global outcome from the beneficiaries' standpoint. We're not there yet, but as an organization that is what we ought to speak to.

Then we ought to speak to the example of the American College of Surgeons and the pilots and so forth, and then work our way down to whatever the recommendation would be. All I'm saying is I'm not certain as I sit here today which way I'd vote on that.

I have a dear friend, high school classmate who swears his life was saved by one of these people, because she not only was with him in surgery, she stayed with him when the doctor wouldn't be with him and things like that, while he was recovering and helped him with his therapy and a bunch of things like that. So I am sure if he were here he would want me to side with --

But I would just like to stress the conversation that went around the table which is, this is not the donkey, this is not the camel, but the global is the direction that the payment system should be going if we are thinking about beneficiaries. So I am speaking largely only to the report language that goes with whatever the recommendation we come up with.

MR. SMITH: It might be possible to do both, to lay out the argument that David just did, not join the issue that Alan correctly says we're not ready to join, and still make the equity point about reasonably similarly situated folks who ought to be able to get paid for doing the thing that their colleagues can do, and we can do that in a budget neutral way. It seems to me we can say, we wished you'd asked us a different question. We wished times were different so that you asked us different questions. You didn't. But here's what we would have said if you had. In the meantime, here's an answer to the question you did ask us.

MR. HACKBARTH: Again, let me just draw a distinction. I wouldn't have any qualms in principle about responding to this question with a comprehensive solution. It's not the narrowness of the question that takes me away from that. What takes me in a different direction is, I don't think, as appealing as this is, and I don't deny that, I don't put it at the top of my list of priorities for people to invest time and effort at CMS. Having been there I guess I have some sympathy for what we ask of them, and we ask way more than they can reasonably produce.

DR. MILSTEIN: Just to get a sense of, if we were to move in the direction of the more innovative recommendation, in terms of calibrating the degree to which it is an opportunity to learn versus a complete overhaul of how Medicare pays for surgeries, maybe you said this earlier but if so could you just remind me, what percentage of total Medicare inpatient spending for surgery for the procedures for which this is absorbed by the procedures to which this question of a first assistant applies? Is first assistant at surgery 10 percent of Medicare surgery or 90 percent?

MR. GLASS: I can't answer that directly because we don't know -- if there isn't a separately payable person doing it, we don't know if it happened. But for those procedures that the ACS said should almost always have a first assistant, 36 percent had a separately billable first assistant. We're assuming the other 64 percent had a first assistant but they weren't separately billable because they're a resident or they're a CRNFA or something else. The American College of Surgeons says 1,700 different procedures should always require one, and then there was some number that sometimes should and 1,700 or something that should never have one. But I don't know how many that means in terms of how many of those each happened a year. We could find that out if you want.

DR. MILLER: In some of our conversations back and forth you had said that at one point in time there was a proposal for a demonstration of sorts on this. Can you just remind what that was?

MR. GLASS: This being pay CRNFA, in a Senate amendment which actually later became our study, it was first a demonstration program. It was to be in five states for three years and then an assessment made of its cost-effectiveness and quality of CRNFA versus other people doing first assisting. So that demonstration was in the Senate amendment. It wasn't in the final version. It got changed into us doing a study of it

instead.

Now I think there is also a demonstration of this bundling of surgeon and hospital fees is underway, though I'd have to check on that to see if that's affecting payment or something else. But I think there's something called the Virginia study. So there is a demonstration on the bundled I think, but I'd have to check on the details.

MR. HACKBARTH: It might be interesting to hear more about that next time.

DR. CROSSON: Let me just ask with respect to this issue, if we were to allow them to bill separately, what would budget neutral mean in that context? I can't tell from this whether the expectation is that they save money or they cost money, and how we would --

DR. MILLER: Part of the reason why it's hard to say that is because although you see the physician first assistant expenditures going down, it's hard to tell whether that's a secular trend of not, or whether there's truly a substitution here. So part of judging the budget neutral also requires making a judgment of whether that's a trend or whether there's a substitution there. I think honestly we don't know. It may be some of both. So that's one comment. Another part of your question is, budget neutral, what does that mean? There's really only two ways I think this can work, and I'm thinking out loud here. But one way to make it budget neutral is you make an estimate of what the expenditures would be under this and then you take it out of the hospital payment, or you take it out of the physician payment, although that's a little bit more difficult because that's paid on a per-service type of basis.

MR. SMITH: Or you move 85 to 82.

MR. GLASS: Or I think we proposed in an earlier, the one that had to do with the nurse midwives, that you adjust the conversion factor to make it budget neutral. To the extent that they are replacing residents, I guess you could argue take it out of GME.

MR. HACKBARTH: Any other thoughts on this?

We will revisit this again next time. Let us digest the comments and try to come back with something that reasonably takes most of them into account.

I think that's it for today except for the public comment.